NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER Health Services STATEMENT NUMBER 6.18
SUBJECT: **INVOLUNTARY EMERGENCY MEDICAL AND/OR PSYCHIATRIC TREATMENT**	EFFECTIVE DATE 11/15/01 REVIEW DATE 11/15/02 SUPERCEDES PPD# 6.18 DATED 11/15/97
ISSUING OFFICER: *Phil Stanley, Commissioner*	DIRECTOR'S INITIALS APPENDIX ATTACHED: YES NO
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:
To provide guidance in administering emergency involuntary treatment to residents of Departmental facilities.

II. APPLICABILITY:
To all Department of Corrections personnel.

III. POLICY:
The Department of Corrections has an affirmative duty to maintain the general health and well being of persons under Departmental control. Such persons whose medical or psychiatric condition requires expeditious emergency medical and/or psychiatric treatment to prevent (1) death; (2) substantial worsening illness or injury; or (3) contagion or infection of others, shall be treated in the least intrusive manner over the objection of the individual resident or legally responsible person, in accordance with State and Federal laws.

IV. PROCEDURES:

A. For the purposes of this directive, emergency shall mean the physical or mental status of a resident which, if not treated promptly, likely will result in substantial harm to the resident or others.

B. Such persons whose medical and/or psychiatric condition requires, in the opinion of a departmental physician, expeditious emergency medical and/or psychiatric treatment to prevent (1) death; (2) substantial worsening illness or injury; or (3) contagion or infection of others shall be treated in the least intrusive manner as prescribed by the Physician or Psychiatric Mental Health Advanced Registered Nurse Practitioner (PMH ARNP) over the objection of the individual resident or legally responsible person.

C. In the case of an incompetent resident, emergency treatment may be administered when the Physician/PMH ARNP or designee reasonably believes that no one competent to consent can

be consulted and that a reasonable person concerned for the welfare of the resident would consent.

D. Legally responsible persons (guardians, closest next-of-kin, or in the case of minors, parents) shall be consulted before the proposed treatment, if possible, but in no event later than 24 hours after the administration of such treatment. Said contact shall be documented in the resident's medical record.

E. Involuntary emergency medical and/or psychiatric treatment shall be administered by said Physician/PMH ARNP or designee only upon personal examination and/or observation by the physician prior to the decision to administer the treatment, except in situations where emergency physical or mechanical restraint or seclusion is necessary as described in paragraph I below. Seclusion/Restraint is considered medical/psychiatric treatment limited to a treatment setting.

F. In all cases, a second medical or psychiatric opinion shall be sought if deemed appropriate by the treating Physician or PMH ARNP.

G. Involuntary emergency medical and/or psychiatric treatment shall be limited to the extent that:

1. The authorization to impose involuntary treatment under this policy and procedure shall last for only 72 hours unless a new authorization is secured. When seclusion/restraint is part of a 72 hour involuntary treatment, additional observation and authorization shall be required by the Physician /PMH ARNP for each twenty-four (24) hours of uninterrupted seclusion/restraint.
2. No emergency treatment shall be administered pursuant to this policy and procedure which is not reasonably expected to alleviate or ameliorate the condition which has caused the need for the involuntary treatment.
3. The treatment which is administered shall be a form of treatment which is the least restrictive or least intrusive effective treatment.
4. When an involuntary psychiatric or medical emergency is declared all current physician orders will remain in effect in addition to the involuntary treatment unless otherwise ordered as part of the involuntary treatment. Medications will continue to be offered with the resident retaining right of refusal. Only those medications and treatments ordered as part of the emergency shall be given regardless of consent. At the expiration of the involuntary treatment, all continuing physician orders shall be verified by the Physician/PMH ARNP. The resident's authorization for treatment signed prior to the emergency shall remain in effect after the expiration of the involuntary treatment.

H. Departmental employees should use only that amount of force and restraint necessary to prevent serious bodily harm to the resident or others.

I. Within the Secure Psychiatric Unit such force may include physical restraint, mechanical restraint or seclusion, which may be imposed for a period not to exceed one hour during which time a Physician/PMH ARNP can be consulted to authorize emergency treatment. The Physician/PMH ARNP may authorize the use of restraint or seclusion by telephone order and without personal observation for a period not to exceed four (4) hours. This time period shall begin from the initial placement into seclusion or restraint. Such authorization shall be reviewed and countersigned by a Physician/PMH ARNP on the next duty day or sooner. To continue seclusion or restraint beyond the initial four (4) hours shall require personal observation by the physician before continued uninterrupted administration of such treatment may occur. The order shall be time limited and shall not exceed 24 hours. PRN orders shall not be used to authorize the use of restraint or seclusion. Should the Physician/PMH ARNP

not be available for consultation within one hour of application of restraint or seclusion, or should the Physician/PMH ARNP not arrive within two hours thereafter, the R.N. shall:

1. Notify the Director of Nursing (D.O.N.) and apprise on the lack of availability of the Physician/PMH ARNP administering or directing.
2. Clinically assess the resident's status and implement such measures as deemed necessary to prevent serious bodily harm to the resident or others.
3. Provide thorough and detailed documentation in the progress notes with respect to the reasoning for the measures taken.
4. Actions and measures taken will be reviewed by the M.D., Director of Forensic Services, and the D.O.N. on the next duty day.

J. Prison Facilities: Within the prison facilities such force may include physical or mechanical restraint as described in PPD 5.32 and 5.81.

1. Upon stabilization of the resident, the officer in charge or designee will notify mental health staff. In the absence of mental health staff, the nurse on duty will be notified.
2. Upon notification, a mental health staff member will respond and upon personal examination and/or observation assess the mental health status of the resident.
3. In addition to having a mental status exam by a mental health clinician, the nurse will also be notified for an assessment of physical status.
4. If the mental health responder is the nurse on duty, both a mental health and physical status assessment will be done.
5. At the completion of the assessment a disposition will be made and will include:
    a. behavioral management in the unit
    b. admission to a Department of Corrections Health Services infirmary for further mental health observations
    c. transfer to the Secure Psychiatric Unit
6. If the Infirmary is unable to admit the resident and a transfer to Secure Psychiatric Unit is not possible, the resident will be maintained and under constant observation until a transfer is possible.
7. If a resident is unable to be transferred to an Infirmary site or to the Secure Psychiatric Unit, involuntary treatment necessary to effect a safe transport will be administered in accordance with this policy.
8. The involuntary treatment and transport plan will be a coordinated plan with medical, mental health and security input.

K. When emergency treatment is administered pursuant to this policy and procedure, the mental health/medical staff notes shall reflect events and intervention leading up to the decision for involuntary treatment. The Physician/PMH ARNP administering or directing such treatment shall record in the resident's record the specific reasons for the belief that such involuntary treatment is necessary. Such documentation shall be distributed as follows:

1. The original physician's note and involuntary treatment form regarding said involuntary treatment shall be retained in the resident's record.
2. Copies shall be promptly forwarded to the Commissioner for his review.

L. A resident or legally responsible person may complain against and appeal administration of involuntary treatment under this policy and procedure in accordance with the resident emergency grievance procedures as are applicable given their residential status and place of confinement. The Commissioner shall expeditiously act on the appeal after securing such additional information, advice and expertise as he deems appropriate.

M. Each instance of involuntary emergency treatment shall be reviewed by the Departmental Review Panel consisting of at least the Medical Director of Forensic Services, a second physician, a psychologist and an attorney who shall review the treatment and the circumstances and make such recommendations as appropriate to the Commissioner.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition. Standards

Standards for Adult Correctional Institutions
Third Edition. Standards
3-4362

Standards for Adult Community Residential Services
Fourth Edition. Standards

Standards for Adult Probation and Parole Field Services
Third Edition. Standards

Other

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